PARTNERSHIP FOR HEALTHY AGING IN NIAGARA COUNTY

CLIENT INFORMATION

Name *(Last, First, M.I.):*	**Sex**: ○ M ○ F	**DOB:**
Address:	**Marital status:** ○ Single ○ Partnered ○ Married ○ Separated ○ Divorced ○ Widowed	**Phone** (H):
City:		**Phone** (M):
State:		**Phone** (O):
Zip:		**SSN:**

Living Situation
○ Private-Alone ○ Private-Partner ○ Private-Other Family
○ Private-Other ○ Assisted Living ○ Long-term Care/Nursing Home
○ Inpatient ○ Homeless ○ Unknown ○ Other:

If Other, please specify:

Animals in the home:	**Weapons in the home:**

	Insurance Name	**Insurance ID**
Primary Insurance		
Secondary Insurance		

DEMOGRAPHICS

Race:	**Ethnicity: Hispanic / Latino**	**Preferred Language:**	**Primary Income:**
○ African-American ○ Hispanic ○ Asian-American ○ Caucasian ○ Native American ○ Bi-Racial ○ Other:	○ Yes ○ No	○ English ○ Spanish ○ Other:	○ SocialSecurity ○ Pension/Retirement ○ Disability ○ Earned Income ○ Family ○ Unknown ○ Other:

EMERGENCY CONTACT

Name *(Last, First, M.I.):*			**Relationship:**
Address:			**Phone** (H):
City:	**Phone** (M):	**Zip:**	**Phone** (M/O):

REFERRAL SOURCE

Person Making Referral:	**Date of Referral:**
Agency:	**Telephone #:**

REASON FOR REFERRAL

MEDICAL HISTORY

Mental Health Diagnosis:	**Initial Onset:**
Substance Abuse:	**Medical Problems:**
PMD – Primary Medical Doctor:	

Copy enclosed/ Faxed to 716-278-8130. Attention: Program Supervisor, Community Psychiatric Support and Treatment

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HISTORY OF PREVIOUS TREATMENT

Inpatient Treatment

Inpatient Setting:	Dates:	Reason:	Outcome:

Outpatient Treatment

Clinician:	Dates:	Reason:	Outcome:

In the last 6 months, have you had?

- ☐ Psychiatric hospitalizations
- ☐ Medical Hospitalizations
- ☐ ER presentations
- ☐ Incarcerations
- ☐ Other: _____

LINKAGES / SERVICES

	Telephone:	Ext.		
Agency:			Court System:	
Therapist:			Attorney:	Telephone:
Psychiatrist:			Parole:	
Care Manager:			Probation:	
SNAP: ◯ Yes ◯ No			Task:	
HEAP: ◯ Yes ◯ No			Mental Health Court:	
Medicaid: ◯ Yes ◯ No	Medicaid ID:		SPOA: ◯ Yes ◯ No	Date Application Completed:
Medicare: ◯ Yes ◯ No				
SSI/SSDI: ◯ Yes ◯ No				

Additional Issues to be Addressed:

For Office Use Only: ☐ **ASCM** ☐ **BHCM** ☐ **OACS**

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